

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**DISPUTE RESOLUTION FOR MEDICAID  
MANAGED CARE ENROLLEES**



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# EXECUTIVE SUMMARY

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## PURPOSE

To examine the dispute resolution process for Medicaid beneficiaries enrolled in managed care plans and assess how States have implemented Federal due process requirements.

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## BACKGROUND

The Supreme Court established Medicaid beneficiaries' right to due process in 1970 in *Goldberg v. Kelly* (397, U.S. 254, 1970). Due process rights were extended to Medicaid managed care beneficiaries in 1993 in *J.K. v. Dillenberg* (836 F Supp. 694, 699 D AZ 93). To fulfill due process requirements, States must guarantee all Medicaid beneficiaries access to State fair hearings when their benefits are adversely affected by a government action. In addition, any managed care plan that contracts with a State Medicaid agency must operate its own internal grievance process. States may require managed care enrollees to exhaust the internal plan process before granting a request for State fair hearing. States and plans must issue and publicize their dispute resolution procedures.

We conducted on-site reviews at nine States selected on the basis of Medicaid and managed care enrollment, geographic diversity, and program diversity. For each State, we collected data from Health Care Financing Administration (HCFA) personnel, State Medicaid agency staff, fair hearing officers, the State Attorney General or equivalent, managed care plan staff, and legal advocates. We analyzed State policies, regulations, guidelines, and enrollee information including beneficiary handbooks and notices.

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## FINDINGS

Overall, the dispute resolution systems in the nine States we studied appear to be working as intended. There are, however, opportunities for improvement.

**Dispute resolution systems have been established in the sampled States.** Beneficiaries have multiple avenues to address any disputes they have with their managed care plans. These include internal grievance processes, State fair hearings, ombudsman programs, and processes operated by other State agencies. Beneficiaries appear to be well-served by this array of options; however, advocates and others are concerned that the diverse choices may cause confusion. In-plan processes can be difficult to access, but also effective. State fair hearings are generally user-friendly and accessible. A number of managed care plans serve both Medicare and Medicaid beneficiaries and must maintain different dispute resolution system for each programs.

**States conduct few managed care hearings, and managed care organizations receive relatively few complaints and grievances.** Requirements to exhaust plan processes, the availability of alternative procedures, and a prevailing attitude of avoidance may contribute to the low numbers of hearings, complaints, and grievances. Furthermore, managed care plans may be misreporting complaints as simple inquiries, and beneficiaries may not have a clear understanding of their appeal rights.

**Member materials and notices are often inadequate.** Although member materials from all States and plans contain some information about appeal procedures, they vary widely in quality. Beneficiary notices also contain many deficiencies, and some seem to require advanced comprehension skills. Despite the overall poor quality of materials, we did find some promising approaches in a few States.

**Regulations governing fair hearing timeframes are flexible, but can be ambiguous.** States utilize Federal flexibility to institute different timeframes for filing a fair hearing request. Regulations do not address the coordination of State and plan processes, which can be problematic.

**States have different interpretations of the plan's role, as well as their own, in fair hearings.** In some of the sampled States, managed care plans represent the State's interest in fair hearings and beyond, while in others the plan is seldom, if ever, a party to the hearing. Two States have arrangements which seem to violate Federal rules for the impartiality of hearing decisions. Finally, while Federal guidelines state that a fair hearing decision must be extended to all beneficiaries in an identical situation, hearing decisions are not precedential.

**Oversight of dispute resolution is inconsistent.** The HCFA regional offices conduct very little oversight of dispute resolution in States' Medicaid managed care programs. While many States conduct rigorous oversight of plans, others adopt a more relaxed attitude. In addition, there is little coordination among agencies in States with multiple dispute resolution processes. Furthermore, lack of consistent definitions of dispute terminology complicates oversight for both HCFA and the States. Data quality in the States varies; however, States that view complaint data as an opportunity for improvement believe plan data is reasonably accurate.

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## RECOMMENDATIONS

A final rule published by HCFA in the January 19, 2001 Federal Register addresses problems we found regarding inconsistent dispute terminology, unclear dispute timeframes, and beneficiary education and notification. The rule becomes effective on

June 18, 2001. To further strengthen the dispute resolution process, we recommend that HCFA:

- <     **develop model beneficiary notices and handbooks;**
- <     **improve regional oversight; and**
- <     **use, and encourage States to use, dispute resolution data as a way to improve quality of care.**

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## **AGENCY COMMENTS**

We received written comments from HCFA on the draft report (see Appendix). The HCFA concurred with our recommendations. In response to our recommendations, HCFA will improve Medicaid consumer communications, regional oversight of the appeals process, and dispute resolution data.

# TABLE OF CONTENTS

	PAGE
<b>EXECUTIVE SUMMARY</b> .....	1
<b>INTRODUCTION</b> .....	5
Purpose .....	5
Background .....	5
Methodology .....	9
<b>FINDINGS</b> .....	10
Systems in place .....	10
Few hearings and grievances .....	12
Inadequate member materials .....	13
Timeframes ambiguous .....	14
States' and plans' roles .....	15
Inconsistent oversight .....	16
<b>RECOMMENDATIONS</b> .....	18
<b>APPENDIX</b> .....	20

# INTRODUCTION

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## PURPOSE

To examine the dispute resolution process for Medicaid beneficiaries enrolled in managed care plans and assess how States have implemented Federal due process requirements.

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## BACKGROUND

### Medicaid and Managed Care History

Congress created Medicaid in 1965, under Title XIX of the Social Security Act, as a joint Federal/State program to serve disadvantaged people. Although the Health Care Finance Administration (HCFA) retains regulatory authority over the program, States have been given significant latitude in developing their own Medicaid policies. Within broad Federal guidelines, States establish their own eligibility standards, determine what services they will cover, set payment rates for services, and administer their own programs. Low-income families and Supplemental Security Income recipients are among the primary beneficiaries of Medicaid. In December 1999, more than 32 million people, about 11 percent of the total U.S. population, were enrolled in the program.

Under Title XIX, States may operate voluntary managed care programs without special permission, but must apply for waivers to mandate enrollment or to be exempt from certain requirements. Research and Demonstration Waivers (or 1115 Waivers) permit HCFA to authorize experimental, pilot, or demonstration projects which are likely to promote Medicaid program objectives. Among other things, States granted a 1915(b) “Freedom of Choice” waiver may mandate enrollment into managed care and create “carve-outs” for the delivery of specific sets of services, such as mental health services, in a managed care environment.<sup>1</sup>

The Balanced Budget Act of 1997 eliminates waiver requirements for most Medicaid populations.<sup>2</sup> States may now elect the 1932(a) State Plan option to mandate enrollment

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<sup>1</sup>States could also apply for a 1915(c) Home and Community-Based waiver, which allows States to develop systems of non-institutional care for Medicaid beneficiaries. Programs created under such waivers are not a focus of this study.

<sup>2</sup>Waivers are still required for dual-eligibles (beneficiaries qualified for both Medicare and Medicaid), children with special needs, and American Indians.

in managed care, provided the beneficiary has a choice between at least two plans.<sup>3</sup> It also adds increased protections for managed care enrollees as specific requirements for contracts between States and plans, including very specific provisions for plans' internal grievance procedures.

Currently, 49 States have used the freedom granted by waivers and the State Plan option to move all or part of their Medicaid population into managed care. As of December 1999, almost 18 million, over half of all Medicaid recipients, received services through one or more managed care plans. Medicaid managed care organizations are the most common type of plan and enroll over 12 million beneficiaries. These plans strive to provide comprehensive and preventive services to members. Prepaid health plans serve more than 8 million, and provide a limited set of services or a set benefit package. States use primary care case management providers, usually physicians, to locate, coordinate, and monitor the delivery of services for over 4 million beneficiaries. We use the term "managed care plan" or "plan" to refer collectively to these three types of managed care, except in discussion of plans' internal grievance processes.

## **Dispute Resolution under Medicaid Managed Care**

In 1970, the Supreme Court guaranteed recipients of government assistance broad due process rights. Under *Goldberg v. Kelly* (397, U.S. 254, 1970), the Court held that beneficiaries of Federal entitlement programs are accorded constitutional protections when their benefits are adversely affected by government action. These rights were extended to Medicaid managed care beneficiaries in 1993 in *J.K. v. Dillenberg* (836 F Supp. 694, 699 D AZ 93). The Court stated that "... it is unreasonable to presume that Congress would permit a State to disclaim Federal responsibilities by contracting away its obligations to a private entity." The right to a fair hearing under Medicaid managed care was further strengthened in a 1995 decision by the 2<sup>nd</sup> Circuit Court of Appeals (*Catanzano v. Dowling*). The Appeals Court found that an independent contractor did not have unilateral authority to reduce services without notifying the beneficiary, allowing a hearing on the matter, and providing aid-continuing rights.

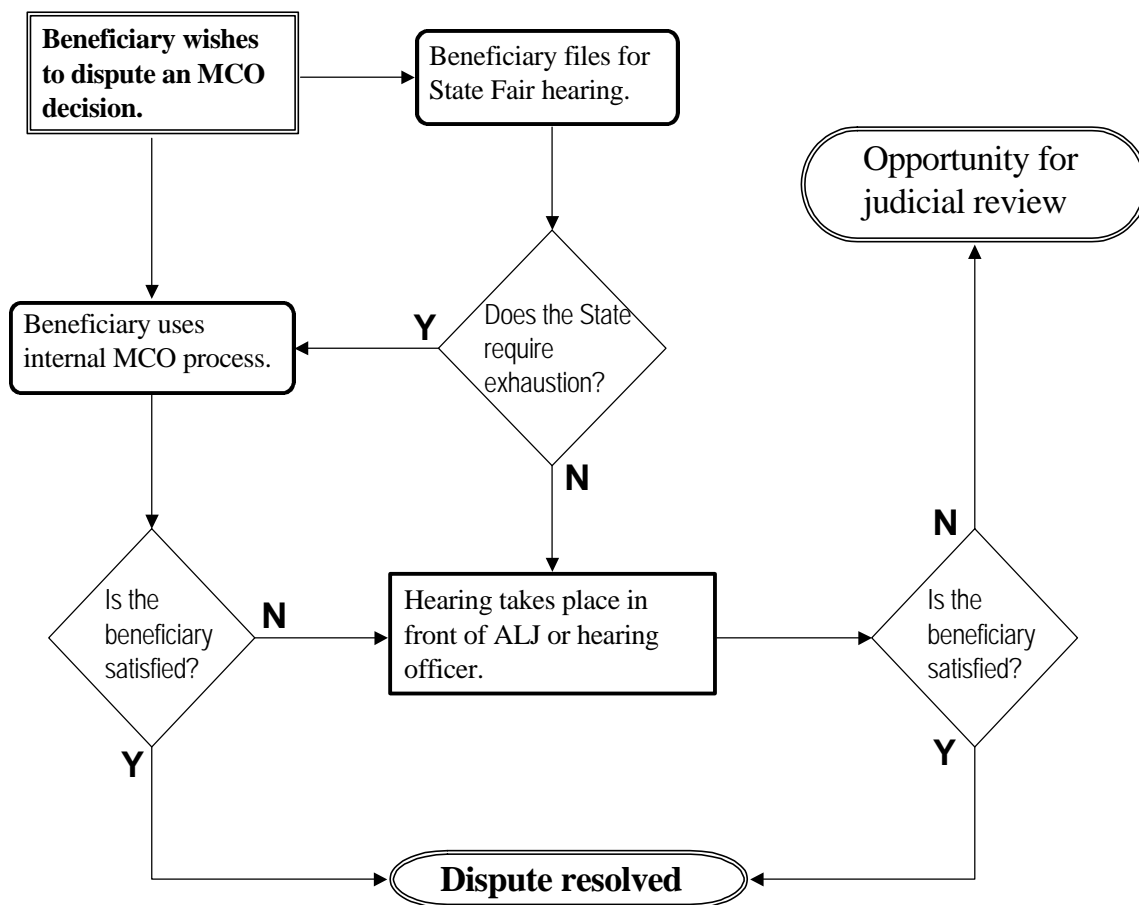
To fulfill due process requirements, all States must guarantee Medicaid beneficiaries access to State fair hearings. The specifics of the process vary greatly by State, but the basic structure described in Figure 1 is fairly constant. In general, beneficiaries must file within a specified time to have their case heard by a State fair hearing officer. This hearing officer may be an Administrative Law Judge (ALJ), and can be part of the State Medicaid or other State agency. The hearing is often conducted in person, and any party to the hearing may have legal representation. The hearing officer or ALJ issues a recommended decision which is reviewed and finalized by another party, such as the head of the agency conducting the hearing. The beneficiary may petition the State judicial system if dissatisfied with the outcome of the hearing, in which case the Attorney General or agency's general counsel would represent the State's interest.

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<sup>3</sup>States may waive the 2-plan requirement in rural areas, if a single eligible plan meets certain conditions.



**Figure 1: Basic Dispute Resolution**



All contracted plans must operate their own internal grievance process. In States with an “exhaustion requirement,” beneficiaries must follow this process to completion before filing a hearing request. Like the States, plans are usually afforded much latitude in developing their own dispute resolution procedures. As a result, it is difficult to describe a ‘typical’ plan process, though most include several levels of internal review. Since primary care case management plans do not operate an internal grievance process, their enrollees either file directly for a fair hearing or go to a State grievance process, depending on their State.

## New Regulations

To implement provisions of the Balanced Budget Act, HCFA published a final rule on January 19, 2001 (after we had completed our fieldwork) which amends the Medicaid regulations. The regulations are scheduled to become effective on April 19, 2001. Among other provisions, the rule significantly increases regulatory requirements for plans’ grievance processes. For instance, although the following provisions generally appear in contracts, the rule mandates that all Medicaid plans:

- < provide a dispute resolution system including grievance and appeal processes as well as access to the State fair hearing system;
- < provide an expedited grievance process when warranted by a beneficiary's medical condition; and
- < track and maintain a log of all grievances and appeals.

The final rule includes provisions for creating a national standard for dispute terminology. Currently, States and plans do not use consistent terminology to describe aspects of their grievance systems. When implemented, the rule will define an appeal as “a request for review of an action,” a grievance as “an expression of dissatisfaction about any matter other than an action,” and a quality of care grievance as “a grievance filed because the enrollee believes that any aspect of [their] care [was substandard].”

The final rule also delineates plans’ responsibilities for educating and notifying beneficiaries about plan decisions and grievance and appeal rights. Under current regulations, States must issue and publicize their fair hearing procedures in language that can be understood by beneficiaries and must notify beneficiaries of their right to a fair hearing whenever there is:

- < a denial of eligibility,
- < an unreasonable delay in acting upon a claim,
- < a termination of eligibility or covered services,
- < a suspension of eligibility or covered services, or
- < a reduction of eligibility or covered services.

The new regulations require that managed care plans distribute their grievance and appeal procedures to beneficiaries as well, including their right to State fair hearing. Plans must provide notice when they; terminate, suspend, or reduce previously authorized services; deny payment on a claim; or deny or limit a service request.

## Previous Work

A recent National Health Law Program study found that beneficiaries often face significant challenges when resolving service disputes with a managed care organization. Obtaining medical records, understanding notices, and even calling the health plan for assistance can be troublesome for Medicaid beneficiaries, who by definition, have limited resources. These difficulties are compounded for individuals who are illiterate or lack access to a telephone.<sup>4</sup> Work by other advocacy organizations supports the finding that Medicaid managed care enrollees have difficulty exercising their rights.

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<sup>4</sup>Kristi Olson, J.D. and Jane Perkins, J.D., M.P.H. *Medicaid Managed Care and Due Process: The Law, Its Implementation, and Recommendations*, National Health Law Program, May, 2000.

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## METHODOLOGY

We selected a purposive sample of nine States for this study. In Iowa, we focused on the State's behavioral health carve-out. Figure 2 shows the States we visited and the enrollment

**Figure 2: Medicaid Managed Enrollment by State**

As of December 31, 1999 according to HCFA's website

State	Medicaid Enrollment	Medicaid Managed Care Enrollment	Percent in Managed Care
California	5,023,266	2,606,524	51.9
Florida	1,594,757	959,875	60.2
Iowa	207,830	179,462	86.4
Maryland	475,014	386,012	81.3
Massachusetts	910,493	647,018	71.1
Minnesota	446,635	268,288	60.1
Missouri	719,684	297,705	41.4
Tennessee	1,348,677	1,305,619	96.8
Washington	728,794	712,698	97.8

information used to select them. In addition to these criteria, we based our selection on geographic and program diversity. During the selection process and throughout the study, we worked closely with HCFA and the Assistant Secretary for Planning and Evaluation.

In each State, we interviewed State

Medicaid agency staff, fair hearing officers or Administrative Law Judges, and the Attorney General or Office of General Counsel. We also spoke with at least one legal advocacy organization and reviewed at least one plan in each State. Finally, we met with HCFA personnel from each region visited. In total, we interviewed more than 160 individuals involved with Medicaid managed care dispute resolution.

We analyzed State policies, regulations, guidelines, and enrollee information, including educational materials (i.e., member handbooks) and beneficiary notices from the nine States. We also conducted a thorough literature review to identify legal and policy work on Medicaid dispute resolution.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

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## Dispute resolution systems have been established in the sampled States

### Beneficiaries have many options

In every State that we visited, Medicaid managed care enrollees have multiple avenues to address any disputes they have with their managed care plan. In addition to the internal plan process and the State hearing (except in Massachusetts<sup>5</sup>), five of the nine States have Statewide ombudsman programs, while two others operate programs in a limited area. These programs assist beneficiaries through either plan or State processes, and may also act on the State's behalf in tracking dispute activity. The State Medicaid agencies in two other States investigate complaints outside of the fair hearing process. In four States, beneficiaries may bring a dispute to an outside agency, such as the Department of Insurance, rather than request a fair hearing.

While Medicaid beneficiaries appear to be well-served by this array of options, advocates and others express concern that the number of processes may confuse clients. Indeed, it is not always clear from notices and educational materials why one would choose one process rather than another. For example, beneficiaries in one State have five separate choices for pursuing a dispute, each with its own rules. In several States, outside agencies typically just refer clients back to the State or plan to seek resolution. This could be extremely frustrating for people who are already unhappy with their situation. Furthermore, informal processes in some States may actually act against beneficiaries' right to a fair hearing, as in the case of the "ombudsman" programs in two States that actually define their role as trying to mediate a solution and "avoid going to the ALJ."

A number of managed care plans serve both Medicaid and Medicare beneficiaries. Such plans must maintain different dispute resolution systems for each program. Several plan representatives we interviewed commented that dealing with multiple processes was cumbersome and inefficient.

### In-plan dispute resolution can be difficult to access, but also effective

In-plan dispute resolution processes usually involve multiple layers of review which, in some cases, may be difficult to access. While the lowest level of review is usually triggered by phone contact, higher levels require written notification to the plan. To file a grievance at one plan, the

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<sup>5</sup>Massachusetts has ruled that provider or plan actions are not State actions. Therefore, beneficiaries cannot bring a dispute with their plan to a fair hearing.

member must provide very specific documentation, including a record of each contact the member has made with the plan about the problem with dates and names as well as a request for a specific resolution of the issue. We found nothing in the health plan's policy or member materials which indicates that this requirement has been communicated to plan members. Rather, plan documents indicate that if these materials are not included, a grievance request should simply be denied. Procedures at this and other plans also stipulate that the member is responsible for obtaining and submitting any pertinent medical records from their provider.

If successfully accessed, using a grievance process can be an effective and efficient way to resolve disputes. Most of the plans to which we spoke indicated that they resolve more than 90 percent of disputes to the member's satisfaction at the lowest, or "complaint," level. Plan processes can be very effective at clearing up "minor" issues such as missing member materials and personal conflicts between providers and patients. Plans are able to resolve issues quickly; usually, they can satisfy members at the time of contact. Each plan overturns a significant number of their own decisions at some level of review, from about 20 percent of decisions at one plan to well over 50 percent at several others.

## **Hearing officers try to provide user-friendly hearings**

Every State we visited complies with HCFA requirements for the impartiality of hearing officers, but they employ very different people in that role. Six of the nine States use ALJs to hear cases, while the other three use hearing officers with varying degrees of training. No sampled State has hearing officers or ALJs dedicated solely to managed care cases, though many specialize in "general" Medicaid. While some State Medicaid agencies use independent agencies to conduct hearings, a division of the Medicaid agency hears cases in other instances. Hearing officers who operate independently from the State agency believe this separation is critical in getting beneficiaries to trust the system.

The State fair hearing is generally a user-friendly process. Hearing officers, State Medicaid agencies, and advocates typically describe the tone of the hearing as "informal" or "non-adversarial." Since most beneficiaries are not represented by a lawyer, hearing officers are usually very lenient with them in terms of rules of evidence. Indeed, advocates in several States laud hearing officers for their fairness and equity. In some instances, the State agency may even help the beneficiary by suggesting they present certain evidence which supports their case. Despite the general good feeling about the hearings, some advocates and ALJs believe that the process is inherently unfair. They maintain that the leeway accorded *pro se* clients does not always compensate for clients' lack of medical or legal expertise where the State or plan frequently has one or both readily available.

We found that, as mandated by Federal regulations, States provide the opportunity for beneficiaries to attend a hearing in a forum that is reasonably convenient to them. The primary location for hearings is the local assistance office in many States, but the beneficiary can request a telephone, video-conference, or even in-home hearing if needed. In one State, most hearings were actually conducted by phone. Interestingly, advocates in that State complained that a phone conference was very intimidating and limited

beneficiaries' ability to present their case, while advocates in other States generally called for greater access to phone hearings because of their convenience and non-threatening atmosphere.

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## **States conduct few managed care hearings, and managed care plans receive relatively few complaints and grievances**

The sampled States conduct very few fair hearings for Medicaid enrollees in managed care organizations. Excluding Tennessee,<sup>6</sup> the greatest number of 1999 hearing requests in any sample State was approximately 360, in California. Florida reported the fewest number of requests, with only 3 during the past 14 years. Similarly, most plans handle relatively few complaints and grievances, compared to the number of beneficiaries they serve. The actual number varies greatly by plan, from a low of about 50 complaints for one plan in 1999 to about 150 per month at another. The majority of complaints at some plans come from providers rather than members.

Many structural factors contribute to the low number of complaints, grievances, and fair hearing requests. The size of the population enrolled in Medicaid managed care plans obviously influences the number of disputes. The presence of an exhaustion requirement may decrease the number of fair hearings in a State as issues are sorted out in the plans. In open enrollment States, dissatisfied members may simply switch plans or opt out of managed care entirely rather than pursue a dispute. Beneficiaries may choose to use outside agencies in States where they are available. Florida, for example, owes its low number of hearings primarily to its Statewide Provider and Subscriber Assistance Panel which hears Medicaid and commercial appeals.

On the other hand, some advocates and others believe that beneficiaries are not aware of their rights or are reluctant to exercise them. Notices and educational materials often do not provide beneficiaries clear instruction on filing a fair hearing request. Hence, the low number of appeals may be partially due to beneficiaries' lack of knowledge and understanding of their rights. Lengthy grievance processes may discourage beneficiaries from further pursuing a dispute, especially in States which require exhaustion. In addition, beneficiaries may be intimidated by what they view as a very "official" process. Finally, some HCFA regions and State personnel believe that certain plans routinely record issues that are truly complaints as simple inquiries.

The attitude of Medicaid personnel in many of the sampled States may contribute to the low numbers of hearings. In nearly all of the States we visited, State staff tend to view hearings as an undesirable last resort in disputes. Even where exhaustion is not required,

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<sup>6</sup>Tennessee operates its dispute resolution process under a consent decree established in *Daniels v. Wadley* and revised in *Grier v. Wadley (M.D. TN, No. 79-3107)* in which every dispute goes directly to the State Agency. Hence, Tennessee's number of fair hearings in 1999 was abnormally large compared to the other eight States.

beneficiaries are usually encouraged to attempt resolution with the plan before proceeding to fair hearing. For example, a plan in a State that does not require exhaustion told us that, except in egregious cases, the State agency will not grant a hearing request if the member has not worked through the plan process. Regulations in another State allow the Medicaid agency 5 days after a fair hearing request to attempt mediation between the member and the plan. The hearing request telephone line is understaffed and impossible to get through according to nearly all respondents in a third State, which may discourage beneficiaries from filing.

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## **Member materials and notices are often inadequate**

Although member materials from all States and plans contain some information about appeal procedures, they vary widely in quality. Plan membership materials generally have a fairly detailed explanation of the in-plan process, but do not articulate the fair hearing process nearly as well. It is often unclear from reading the materials when a member may request a fair hearing, why one would do so, and by when the hearing must take place. In a few States that do not have exhaustion requirements, member handbooks inaccurately imply that a member must first work through the plan process. Many also fail to inform beneficiaries that they can be represented at a hearing, and none refer beneficiaries to specific legal assistance organizations. State handbooks and pamphlets are little better in most cases; though they contain more detailed information on the hearing, including timeframes, they still fail to direct beneficiaries to legal assistance. In addition, neither State nor plan materials include information about hearing-related expenses such as transportation that might be reimbursed.

Though some are better than others, we found many deficiencies in the notices we reviewed. Overall, adverse action notices do not clearly explain the action being taken and why. Most denial and complaint acknowledgment letters describe the options available for disputing the decision, but they tend to downplay the State hearing process in much the same way as handbooks. When a written request for appeal is required, notices do not specify the form that the request must take and what supporting documents must also be submitted. One plan provides fair hearing information only on the letter which follows the highest level of in-plan appeal. We were told that until recently there had been an exhaustion requirement in the State and the letters still reflected its use. The HCFA had requested that the State drop its exhaustion requirement well over a year before our visit.

Despite minimum requirements in every State for the readability of notices and educational materials, we found much of the language on materials to be unclear and imprecise. Every State imposes minimum requirements on the readability of notices, ranging from 4<sup>th</sup> to 7<sup>th</sup> grade reading levels, but some materials seem to require more advanced comprehension skills. For example, a section of one beneficiary notice reads; “This notification restricts neither you nor your physician’s individual choice of continued medical care and service. However, this determination could result in non-payment of the claims for services provided on your behalf.”

**Figure 3: Useful Form from State Handbook**

**Worksheet – Calling my health plan with a complaint**

Use this worksheet to make notes. It helps you remember what you want to say on the phone. It's also good to have notes of whom you talked to and what you were told. You may need them later if you have a problem.

Date of your call: \_\_\_\_\_

Phone number you called: \_\_\_\_\_

1. Tell the plan about the problem you are having: \_\_\_\_\_

2. Ask the plan what they will do to help with your problem: \_\_\_\_\_

3. Ask the plan how long it will take them to get back to you: \_\_\_\_\_

4. Ask who will get back to you: \_\_\_\_\_

5. Ask the name of the person you are talking to: \_\_\_\_\_

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We also found that few States require that materials have instructions for obtaining documents in another language, or a format for the visually impaired. In addition, some State educational materials have not been updated to reflect the presence of managed care and refer only to a beneficiary's right to dispute a State or county decision.

Despite the overall poor quality of notices and handbooks, we found some promising approaches in a few States. To address language needs, one State mandates that all materials contain a "language block," where the importance of the material and the availability of translation is explained in seven languages. This same State and one other provide very good handbooks which include forms for recording important information from the plan representative when making

a complaint (Figure 3) as well as a form letter for filing a fair hearing request. The hearing agency in another State produces an excellent pamphlet which explains what a beneficiary should bring to and expect from a State hearing. Materials from a few plans clearly and completely explain how and why a beneficiary would use each of the dispute resolution processes available.

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## **Regulations governing fair hearing timeframes are flexible, but can be ambiguous**

Federal regulations intentionally allow States some flexibility in setting fair hearing timeframes. For example, according to the regulations and the HCFA State Medicaid manual, States must provide beneficiaries at least 20, but not more than 90, days to file a fair hearing request after receiving a notice of adverse action. We found that some States permit the full 90 days, while others require filing in 30 or 45 days. Advocates in these States agree that the shorter time periods are still sufficient to allow a beneficiary to request a hearing.



The fair hearing regulations do not address the interaction between hearings and plan grievances. This has caused States to implement dispute resolution timeframes which may not be consistent with the intent of Federal guidelines. For instance, regulations require that final administrative action be taken within 90 days of a hearing request, but do not discuss how using the plan process affects this standard. In all but three States, in-plan dispute resolution alone can take significantly longer than 90 days if all steps are exhausted. Furthermore, beneficiaries who adhere to the plan process could lose their right to file a fair hearing because of its lengthiness, though State officials say they would allow a fair hearing request made after the deadline in such cases.

While plans in all nine States provide expedited timeframes for dispute resolution in urgent cases, only one State includes a description of a formal process for expediting State hearings in enrollee handbooks. Most States require plans to respond to medically urgent issues within 72 hours, though several allowed only 1 day while another permits 5 days. If the plan upholds its determination upon expedited review, further levels of appeal, including fair hearings, are not necessarily expedited. One hearing officer mentioned that hearings can be fast-tracked by an informal request from the State Medicaid agency.

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## **States have different interpretations of the plan's role, as well as their own, in fair hearings**

Federal regulations do not specifically address the role of managed care plans in fair hearings and, as such, they assume very different roles among the nine States. In some, the plan represents the State's interest in fair hearings and beyond, while in others the plan is seldom, if ever, a party to the hearing. In one State, the member and the plan each present their side to an impartial referee from the State. The plan then represents the State in any resulting judicial action. The State Attorney General is concerned about this arrangement, saying that plans might routinely appeal decisions adverse to them since the State pays court costs. In other States, plans are frustrated because their participation is limited to merely providing records before the hearing. Plans in these States do not typically have the opportunity to defend their decision before the hearing officer.

Two States have arrangements that seem to violate Federal rules for the impartiality of hearing decisions. The HCFA State Medicaid manual states that "no person who has previously participated at any level in the determination upon which the final decision is based may participate in the [final] decision." In one State, however, the ombudsman fields all fair hearing requests and attempts mediation and also reviews all hearing decisions before they are made final. In another State, beneficiaries can register complaints with the commissioner of the Department of Health (which is not the State Medicaid agency in that State), only to have that same commissioner act as the final authority on hearing decisions.

Federal guidelines state that a fair hearing decision may be extended to all beneficiaries in an identical situation, but we found that hearing decisions are not precedential. While groups of hearings centered around the same subject area often trigger a change in State policy, single decisions do not. Similarly, hearing officers say that while they may consult earlier decisions to help form an opinion on a case, they do not have to take that case as legal precedent in a parallel situation.

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## **Oversight of dispute resolution is inconsistent**

### **HCFA regions are seldom involved in oversight**

We found that most HCFA regional offices conduct little ongoing oversight of Medicaid managed care dispute resolution. Typically, regional personnel describe their involvement in dispute resolution as “reactive.” That is, they respond to issues brought to their attention but do not regularly review State activity. States are required to report quarterly under 1115 waivers and every 2 years for 1915(b) waivers, but only two States say they regularly submit detailed dispute information. Several other States reported that their regional office performs periodic on-site reviews. Many regions conducted intense reviews when their States first implemented managed care waivers, but rarely conduct reviews now. We found that regional offices varied greatly in the amount of information they could provide us about their States.

If a region uncovers a problem, there is little they can do to compel the State to come into compliance. Although they have sanction authority or may withhold waiver approval, as a matter of practice, regional offices do not often employ these penalties. More frequently, HCFA may impose additional terms and conditions on existing waivers, or delay waiver approval. Though several regions say they have no effective means to compel compliance once the waiver is approved, all report that they can usually work with the State in a cooperative manner to address any concerns.

### **While many States conduct rigorous oversight of plans, others adopt a more relaxed attitude**

Most of the States we visited work closely with their contracted plans in an oversight capacity. All States impose data collection requirements on plans and most use this data to spot trends and address weaknesses in the system. Two States require that plans report all written complaints immediately; one of these also collects monthly data on denials, terminations, and reductions of service. The other States receive periodic reports on plan grievance activity. In most States, agency staff perform annual on-site reviews of the plans, and two States use an external quality review organization to monitor dispute resolution. Lastly, States typically review and approve beneficiary notices and marketing materials before distribution, and some provide mandatory language to be included in notices and handbooks.

A few States are noticeably more lax than others in fulfilling their oversight role. When asked how they ensured compliance with Federal requirements, these States often responded that they relied primarily on the plans' adherence to contracts. Although these States collect data, respondents were unsure how and if the data are being used.

There is little coordination among agencies in States with multiple dispute resolution processes. In some, the State Medicaid agency and the hearing agency may each track appeal cases separately and not share data. In others, Departments of Insurance or Corporations and the State Medicaid agencies impose different, but overlapping, data collection requirements. One State official noted that no communication exists between the Department of Corporations and the State Medicaid agency, even when both are working on an appeal for the same beneficiary and issue.

### **States and plans define and use dispute data differently**

Lack of consistent definitions of dispute terminology complicates oversight for both HCFA and the States. Some States define complaint, grievance, and appeal by how a member contacts the plan; an oral communication is a complaint, a written communication is a grievance, and an appeal is a formal request for reconsideration of the resolution of either of these. Another common distinction is to consider a complaint that remains unresolved after a certain time period a grievance. Still other States use one set of terms to describe disputes about administrative issues and another set for clinical issues. In at least two States, plans use different terminology within the State.

In part due to conflicting definitions of dispute terms, State and plan performance is difficult to assess based on available data. Currently, the inconsistent quality of State data would make it difficult for HCFA to assess a State's performance by just reviewing reports. Similarly, it is nearly impossible to compare plans within a State if they use different definitions for dispute terms. Although reviewing the disposition of cases at the plan level can give some insight into the fairness of the process, it is impossible to judge the quality of decisions by looking at numbers. In addition, plan data show that a significant number of cases are abandoned at each level. A look behind these numbers is necessary to determine if beneficiaries are dropping cases intentionally or if they are not aware of their options for pursuing a dispute.

Perhaps more important is the concern that some plans routinely record complaints as simple inquiries. One plan told us that they do not consider any issue resolved at the time of contact to be a complaint, and therefore do not log all the complaints they receive. This is probably true of other plans as well; another reported receiving over 200,000 calls to customer service in 1999, but only logged 924 complaints and 145 grievances, while a third received 22,464 calls, citing just 198 complaints and no grievances the same year. States may be unintentionally influencing plans by viewing complaints as a negative indicator of plan performance. States that view complaints as an opportunity to better serve beneficiaries and cultivate this understanding at the plans seem to have more faith in plan data.

# RECOMMENDATIONS

Overall, the dispute resolution systems in the nine States we studied appear to be working as intended. There are, however, opportunities for improvement. The final rule published by HCFA in the January 19, 2001 Federal Register addresses problems we found regarding inconsistent dispute terminology, unclear dispute timeframes, and beneficiary education and notification. The rule becomes effective on June 18, 2001. To further strengthen the dispute resolution process, we recommend that HCFA:

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## **Develop model beneficiary notices and handbooks**

Frequently, beneficiary notices and member materials do not adequately explain the dispute resolution process. To encourage innovation, HCFA should continue to allow States and plans to develop their own materials, but should assist them by developing a model explanation of grievance and fair hearing rights. The explanation should be written at the fifth grade level or lower, and it should contain clear instruction on how to access the dispute resolution process. While the final rule outlines notification and information requirements, HCFA may wish to provide template materials as a visual reference for States.

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## **Improve regional oversight**

As noted in the findings, we found several situations where States do not meet Federal requirements. For example, two States apparently violate impartiality provisions and hearing in all sampled States are not precedential. The HCFA should review all States' policies and procedures to ensure that each State is meeting all procedural requirements for the fair hearing process.

We found that the inconsistency of State data makes it difficult for HCFA to assess State performance and compliance. The final rule requires plans to log and track grievances and appeals and submit data at least yearly to the State. We believe that HCFA should require plans to log all calls to the grievance unit, not just those that result in the beneficiary filing a grievance or appeal. Such data may provide clues to possible downcoding at a plan. We also believe that data should be reviewed by the States at least quarterly to help identify emerging issues.

In order to identify national trends and issues, HCFA should develop a standardized quarterly report of grievances, appeals, and fair hearings which States would submit to the HCFA regional offices. This report could be tied to current waiver requirements, but should be detailed enough to provide some insight into States' dispute resolution

activities. Data could then be used to target areas for regional offices' on-site reviews or could trigger an immediate review if necessary. To ensure compliance with reporting requirements, HCFA should aggressively monitor contracts and State data collection systems during implementation of the final rule.

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## **Use, and encourage States to use, dispute resolution data as a tool for improving quality of care**

Treating disputes as an opportunity to strengthen customer service would help to identify weaknesses in the system, improve the consistency of reporting, reduce downcoding, and improve oversight. The HCFA should also encourage States to use dispute data to target areas for quality improvement. One State that we visited successfully uses complaints to continuously improve quality of care and has fostered this practice at its Medicaid managed care plans.

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## **AGENCY COMMENTS**

We received written comments from HCFA on the draft report (see Appendix). The HCFA concurred with our recommendations. In response to our recommendations, HCFA will improve Medicaid consumer communications, regional oversight of the appeals process, and dispute resolution data.

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## Agency Comments

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DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator  
Washington, D.C. 20201

DATE: MAY 10 2001

TO: Michael F. Mangano  
Acting Inspector General

FROM: Michael McMullan   
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Dispute Resolution for Medicaid Managed Care Enrollees* (OEI-09-99-00450)

Thank you for the opportunity to review the above-mentioned draft report. The Health Care Financing Administration (HCFA), along with the States, strives to protect, serve, and promote the interests of our beneficiaries and ensure accountable and prudent management of the Medicaid program.

In the nine states that were surveyed by OIG, dispute resolution systems appear to be working as intended. Medicaid beneficiaries have multiple avenues to address disputes they may have with their managed care plan. However, OIG has advised us that too many choices may cause confusion for some beneficiaries. We will continue to improve Medicaid information to ensure our beneficiaries are receiving the best service possible.

HCFA's responses to OIG's recommendations are as follows:

OIG Recommendation

HCFA should develop model beneficiary notices and handbooks.

HCFA Response

We concur. This recommendation is consistent with other HCFA initiatives to improve consumer communications and to provide complete and clear information about the Medicaid program. We support developing tools for states to use at their option in the management of their Medicaid managed care programs. However, before pursuing the development of model notices and handbooks, we would first consult with states to ensure they are interested in having HCFA produce models.

OIG Recommendation

HCFA should improve regional oversight.

Page 2 – Michael F. Mangano

## HCFA Response

We concur. HCFA has been actively involved in the oversight of the managed care programs. In 2000, HCFA central office (CO) and regional offices (ROs) revised the Medicaid Managed Care Monitoring Guide that is used by HCFA regional office staff for site visits. HCFA CO also uses this guide during joint site visits. The revised guide contains a series of review questions based on requirements relating to complaint, grievance, and appeal rights and processes. Section 1903(m)(2) of the Social Security Act requires HCFA to review and approve most managed care organization contracts. This provides HCFA an early means to oversee state managed care programs.

## OIG Recommendation

HCFA should use and encourage states to use dispute resolution data as a way to improve quality of care.

## HCFA Response

We concur. HCFA encourages, and requires states in every waiver proposal or renewal, to monitor grievances and appeals and submit reports to the ROs. States are requested to send reports that will focus on access and quality of care to HCFA on a regular basis.